Mental Health Parity: Unfinished Business

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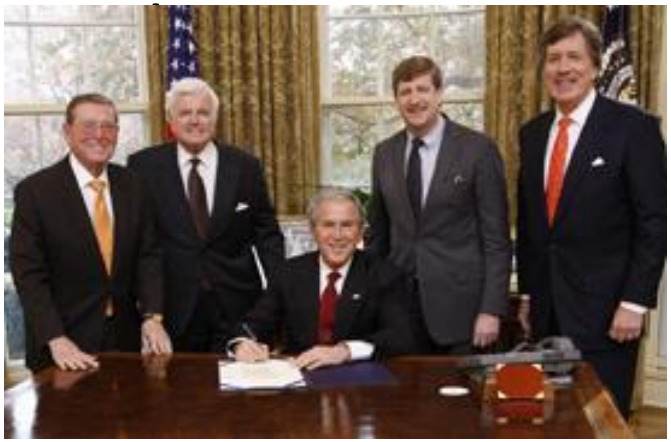
Overview

- Brief Recent History
- What parity is and is not
- What has been accomplished
- What is the unfinished business of parity
- Steps toward completion

Parity

- Prior to 2008 private health insurance for mental health failed to protect against most serious illnesses and costs +
- FEHB and Parity Study =
- Mental Health Parity and Addiction Equity Act,

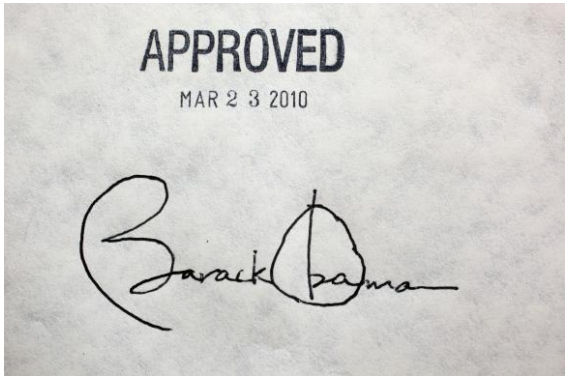


But…

- Limited to firms that offer MH/SA coverage
- Limited to firms with 50+ employees

Behavioral Health Benefits

- EHBs include mental health and substance abuse
- Parity applies to qualified health plans “in the same manner and to the same extent as such section applies to health insurance issuers and group health plans” (sec. 1311(j))



Parity Plus

Universal Coverage

+

Essential Health Benefits -- Coverage Includes Mental Health Benefits

+

Benefits are at Parity

What parity is?

- Mental health parity has it's origins in state laws that regulated insurance benefits (e.g. Massachusetts v Metropolitan Life)
- Parity is fundamentally regulation of insurance benefits and processes
- It is tied to federal statutes that regulate the business and governance of insurance
  - ERISA
  - IRS Code
  - Public Health Services Act
  - Affordable Care Act

What parity isn't

- Reform of mental health delivery in the U.S.
- A quality assurance program
- A framework for design of the "optimal" behavioral health coverage arrangements

- It is benchmarked against medical surgical coverage and practices

Parity in principle vs parity in law

- Parity in principle is providing access to quality behavioral health care within health insurance programs that is on par with access to quality medical care generally
- Parity in law is meeting the requirements of MHPAEA
  - Substantially All and Predominant tests
  - NQTL requirements

Populations with Coverage Affected by MHPAEA and ACA

Group	Policy	Number
Large Insurance Populations	MHPAEA	103 million
Small Group Insurance Market	ACA	30 million
Individual Insurance Market	ACA	18 million
Medicaid	ACA/MHPAEA	23 million
Total		174 million

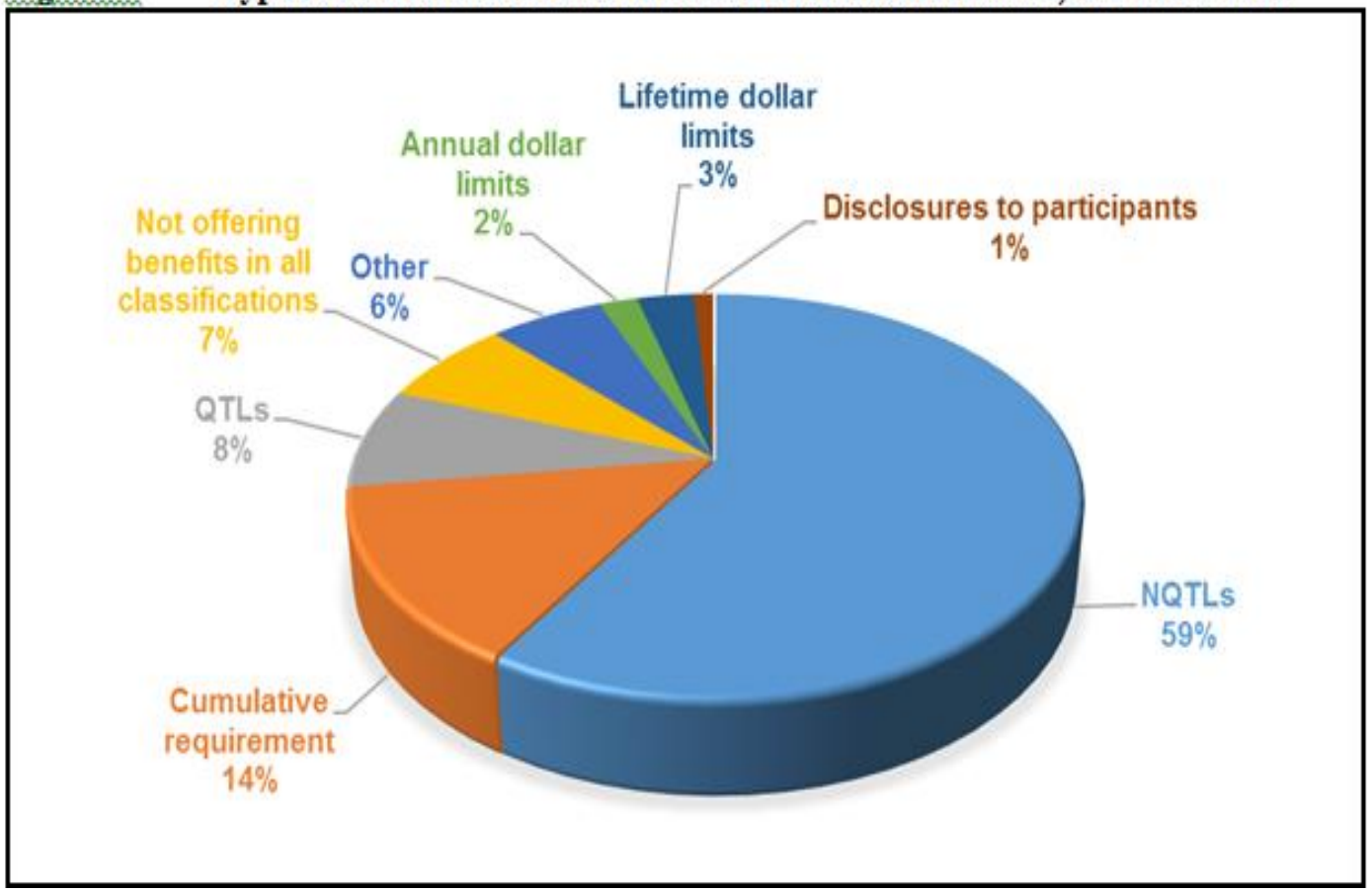
Source: Frank 2016

Improved Coverage

- Initial evaluation showed relatively high levels of adherence to benefit design dimensions of coverage
  - Cost Sharing, day and visit limits largely eliminated (Gopelrud et al; Horgan et al; Thalmeyer et al)
  - Prior authorization fell and 80% of plans report increased network size
- Children's inpatient and outpatient use increased
- Treatment rates for autism increased (Stuart et al)
- Per member per month specialty spending increased modestly (Friedman et al)
- Out of pocket spending reduced even with increased use (Ettner et al)

Parity Shortfalls

Figure 1. Types of Violations Found in DOL Enforcement Actions, FY 2010–2015



Source: U.S. Department of Labor

Incentives

- Adverse Selection incentives
  - Especially in context of high powered payments
- Administrative practices
  - Complex
  - Involve clinical judgements
  - Difficult to measure and enforce
- Performance measurement
- Risk Adjustment
- Accountability

Threats

- Texas v U.S.
  - Medicaid expansion; Insurance expansion/reform; young adult coverage; Medicare Donut Hole closure; consumer protections all go away
- Transitions Plans; Association Health Plans
  - Need not adhere to EHB; Coverage for mental health and SUD care especially affected

History Lesson

2011 Department of Health and Human Services Survey of Individual Market Issuers

- About 65% did not offer maternity coverage in standard policies
- 34% did not offer coverage for treatment of Substance Use Disorders (SUDs)
- 18% did not offer coverage for care of mental illnesses
- When covered M/SUD coverage subject to limits: detox, 30 IP days; 20 OP visits; 50% OP coinsurance

Delivery System Reforms and Mental Health

- Payment and Organizational Change
- Integration
- Prevention/Early Intervention

Delivery System Reform in the Affordable Care Act (ACA)

- Bring more spending under budgets controlled by organizations equipped to integrate and coordinate care
  - Accountable Care Organizations; Health Homes; Special Needs Plans, Medicaid Managed Care Plans.
- Recognizes that we are in early stage of understanding how to scale interventions for vulnerable populations
- Allows states to experiment and develop demonstration programs

High Powered Budget Incentives: Population-Based Payment Systems

- Consolidates funding across service lines
- Moves accountability towards population focus
- Can favor prevention and early intervention approaches
  - Especially for clinical preventive services
- Challenges
  - Business case relies on savings subject to meeting quality thresholds
  - Behavioral health quality measures are under-developed

Consequences

- Potential consequences:
  - We have changed the terms of coverage, but unless we get accountability right, we risk distorting supply in a way that limits potential gains in outcomes
  - In particular, we risk undersupply of care that involves integration of behavioral health and medical care and conditions and people that are best treated using psycho-social care as a component of treatment

What to Measure and How?

- Measuring the quality of care so that it recognizes the integration and appropriate use of psycho-social care is required and difficult
- The challenge is to reward care that is likely to produce good outcomes
  - Ideally we would measure outcomes, but selection risks are high
  - Interim measures of processes that demonstrate integration and effective deployment of psycho-social care may have to be enough
- Measures must be designed to recognize the measure overload environment

Risk Adjustment

- For 50 plus years private insurance has under supplied mental health coverage and care
- Main drivers were incentives to avoid enrolling people with mental and addictive illnesses
- They cost more—both in term of behavioral health and other other medical care
- One must pay plans more for enrolling more costly people—we aren't very good at that in the behavioral health area

Summing Up

- Regulating Coverage and Management of Care is hard especially the Management piece
- NQTLs are one of the first attempt to comprehensively regulate care management practices
  - It is by necessity incomplete
- Addressing underlying incentives is what we need to do to move from parity in law to parity in principle
- There is much other work to be done to make mental health care work better in the U.S. but insurance regulation is not the way to accomplish those goals